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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARY THERESA CAMPBELL** **AKA MARY THERESA ERPELDING** **20 Berkeley Ave.** **San Anselmo, CA 94960** **Registered Nurse License No. 236351** Respondent.	Case No. 2010-609 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 31, 1973, the Board of Registered Nursing issued Registered Nurse License Number RN 236351 to Mary Theresa Campbell, AKA Mary Theresa Erpelding ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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8. California Code of Regulations, title 16, section 1443 states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

STATEMENT OF RELEVANT FACTS

10. On August 26, 2004, patient Linda R.[1] was admitted to the University of California, San Francisco Medical Center ("UCSF") in San Francisco, for abdominal surgery.

11. Surgery was commenced at approximately 9:56 a.m., and was completed at 1:23 p.m. It was more complicated than anticipated, with an estimated blood loss of 800 to 1000 milliliters.

12. Respondent at all relevant times was employed as a registered nurse at UCSF. She was assigned as the circulating nurse in the operating room for Linda R.'s surgery on August 26, 2004. Respondent by her initials on the Intraoperative Nursing Care Record, noted that the final (lap) sponge count was correct.

13. Linda R.'s attending surgeon noted in her operative report that "the sponge, lap and needle counts were correct twice."

14. Post-operatively, Linda R. received intravenous antibiotics and pain medications. Three days after surgery, on August 29, 2004, she was discharged home.

15. On the morning of September 1, 2004, Linda R. was re-admitted to UCSF with complaints of severe right-sided lower abdominal pain, nausea, vomiting and diarrhea. An abdominal x-ray revealed a radiopaque density in the right lower quadrant. Linda R.'s attending

[1] Patient initials are used to protect the patient's privacy. Full names will be disclosed to Respondent pursuant to a request for discovery.

surgeon believed that this was probably a retained lap sponge from her abdominal surgery on August 26, 2004.

16. In the afternoon of September 1, 2004, Linda R. was taken back to surgery and placed under general anesthesia for an exploratory laparatomy. Her prior abdominal incision was re-opened and a retained lap sponge was found. The retained sponge was noted to be adherent to the small bowel, which required the consultation with a general surgeon during the operation. The attending surgeon noted that the "needle, instrument and lap counts were correct x 3. They were counted many times to be certain."

17. Post-operatively, Linda R. was in considerable pain which required higher than usual doses of opiates. She was treated with intravenous antibiotics and due to anemia was prescribed the medication Procrit[2], which can be associated with significant complications. Linda R. was discharged home on September 4, 2004.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Incorrect Sponge Count)

18. Respondent is subject to disciplinary action for gross negligence under section Code section 2761, subdivision (a)(1) in that she failed to accurately complete the final lap sponge count, did not identify the loss of a lap sponge and failed to notify the attending surgeon of the incorrect sponge count as set forth in paragraphs 10 through 14, above. Respondent's gross negligence subjected patient Linda R. to pain, discomfort and with risks attendant in abdominal surgery to remove the retained lap sponge as set forth in paragraphs 15 through 17, above.

SECOND CAUSE FOR DISCIPLINE

(Incompetence – Incorrect Sponge Count)

19. Respondent is subject to disciplinary action for incompetence under section Code section 2761, subdivision (a)(1) in that she failed to accurately complete the final lap sponge count, did not identify the loss of a lap sponge and failed to notify the attending surgeon of the incorrect sponge count as set forth in paragraphs 10 through 16, above.

[2] Procrit is made from human plasma and is injected for use with patients with severe anemia. Its mechanism of action is to cause the body to increase its production of red blood cells.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 236351, issued to Mary Theresa Campbell, AKA Mary Theresa Erpelding.

2. Ordering Mary Theresa Campbell, AKA Mary Theresa Erpelding to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/25/10

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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